Application for Licensure Group Homes for Mentally Retarded Persons

Key the Data in the Appropriate Blocks, Sign and Print the Form, Mail Notarized Application to:

Department of Health
Health Regulation Administration
Health Care Facility Division
825 North Capitol Street, NE 2nd Floor
Washington, DC 20002

Licensure fee should be made to DC Treasurer.
Licensure fees for intermediate care facilities for mentally retarded persons are:
1-4 Beds = $50.00
5-8 Beds = $100.00
9 or more beds = $150.00

(1) Name _____

(2) Name _____

(3) Address _____
_____

(4) Address _____
_____

I/We certify that I/We am/Are twenty-one (21) years of age or older and of reputable and responsible character and do hereby apply for a License to operate a Group Home for Mentally Retarded Persons (GHMRP) during the _____ calendar year.

I/We agree to comply with all applicable laws and regulations of the District of Columbia and any terms or conditions applicable on the basis of this application. I understand the requirements of these regulations and am capable of providing adequate care to residents of the Group Home for Mentally Retarded Persons for which I/We am/are responsible.

Name of Facility _____

Telephone _____

Type of Facility [ ] Level 1 (CRF/MR) (Fees) [ ] Level 2 (ICF/MR)

Location _____
Street

_____
City/State Zip Code

Full Name of Owner(s) if Business
(1)_____
(2)_____
[If owner of business is a Corporation or Partnership, attach names and addresses of officers of the corporation and or partners; also submit Letter of Good Standing.]

1. Residence Director: _____
First Middle Last

Home Address _____
Street

_____
City/State Zip Code

Birth Date: _____ Telephone: _____

Highest Level of Education Completed: _____

2. Number of Beds: _____

GHMRP Residents: _____

Others: _____

(Specify) [ ] Female [ ] Male

3. Staffing: Number of Rotating Staff _____
Number Staff Living on Premises _____

4. Certificate of Occupancy # _____

5. Insurance Coverage—There is attached documentary evidence of financial responsibility on the part of the applicant as stipulated below:

A. Hazard (fire and extended coverage): Minimum of $500 per resident or $2,000 per facility.

Name/Address of Company: _____

_____

Amount of Coverage: $ _____

B. Liability Insurance - Minimum of three hundred thousand ($300,000) per occurrence.

Name/Address of Company: _____

_____

Amount of Coverage: $ _____

Professional Liability (Explain) _____

License Fee $ _____ Make check payable to DC Treasurer.

(Fee is not refundable.)

Signature(s) of Applicant(s):_____

Sworn and subscribed to before me this _____day of

_____20_____.

_____

Notary Public District of Columbia

My commission expires_____(Seal)

Mail completed application to:
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TO REPORT WASTE, FRAUD, OR ABUSE BY ANY DC GOVERNMENT OFFICE OR OFFICIAL, CALL THE DC INSPECTOR GENERAL AT 1-800-521-1639.